Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-08-1055-01
ACCESS MEDIQUIP LLC P.O. Box 421529 Houston, TX 77242	DWC Claim Injured Emp
Respondent Name and Box #:	Date of Injur
Texas Mutual Insurance Co. Re Box: 54	Employer Na Insurance Ca

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Billed 16 electrodes only paid 2. Requesting additional payment 14 electrodes".

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $6,518.54
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...This requestor billed for 16 units of code L8680 (neurostimulator electrodes) for multi contact electrodes. Per AMA CPT Assistant; June 1998; Pain Management: Spinal Cord Stimulation, the metal on the electrode that provides the electrical contact in the epidural space is called a contact... It is this carrier's position that each contact of a single array is not due individual payment; however, each single implantable electrode array is reimbursable, therefore, two neurostimulator electrode were used and reimbursed. Texas Mutual believes no further payment is due for the multiple contacts billed..."

Principle Documentation:

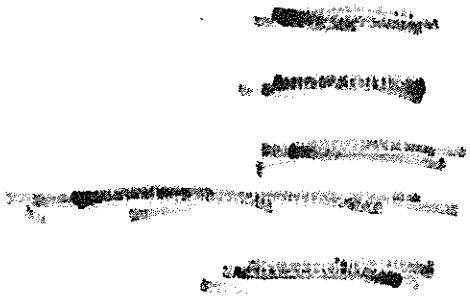
1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01/08/07	W10, W4, 426, 891	L8680 (16 x $465.61 – $931.22 (payment))	1, 2	$6,518.54
Total Due:				$6,518.54

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.



1. HCPCS Code L8680 was denied by the Respondent with reason codes "W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology", "426 – Reimbursed to fair and reasonable", "W4 – No additional reimbursement allowed after review of appeal/reconsideration", "891 – The insurance company is reducing or denying payment after reconsideration."

2. Per Rule 134.202(b) research of policies for HCPCS Code L8680 reveals that policy changes made in January of 2002 allow for separate reimbursement for each electrode rather than arrays. The HCPCS code used for implantable neurostimulator electrodes changed from E0752 to L8680 in January 1, 2006. Therefore, per 134.202(c)(2) reimbursement in the amount of $6,518.54 ($465.61 x 16 ($372.49 x 125%) = $7,449.76 - $931.22 (payment received) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $6,518.54 plus accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

[redacted] [redacted] January 28, 2008

Authorized Signature — Team Lead, Medical Fee Dispute Resolution — Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.